Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR WILLIAM SMITH
2825 I 10 EAST SUITE 112
BEAUMONT TX 77702

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-1870-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "sent HICFA and report to the insurance adjuster 'Sona Stein' on **02/07/2011**…sent a final notice to the adjuster stating that the claim will be forwarded to TDI if the bill is not expedited immediately. Sent on **12/12/2011**…sent a letter to the insurance adjuster stating that the bill is still outstanding. Attached to the letter is the 32 Form, HICFA, report, confirmations, and narratives. Sent on **12/12/2011**…sent an email to the adjuster with the HICFA, 32 Form, narratives, reports, and confirmations attached. Told the adjuster that the claim has yet to be paid and that the bill is still outstanding. Sent on **11/04/2011**…Call log shows that we called the adjusters office two times on **12/12/2011** and left a message. We received no reply of any kind."

Amount in Dispute: $1,250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response for consideration to this dispute.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 24, 2011	99456-W5	$650.00	$0.00
	99456-W5	$150.00	$0.00
	99456-W5	$150.00	$0.00
	99456-W5	$150.00	$0.00
	99456-W5	$150.00	$0.00
TOTAL		$1,250.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. Copies of explanation of benefits were not submitted by either party for review. The disputed services will therefore be reviewed per the applicable rules and fee guidelines.

Issues

1. Were the services in dispute appropriately billed?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor billed the amount of $1,250.00 for CPT Code 99456-W5 X 5 for a Division ordered Designated Doctor examination for 1 body areas/units in box 24G of the CMS-1500. Review of the documentation supports that MMI was assigned and two (2) body areas were rated. The left wrist and left knee are the two areas claimed as rated.

   CPT code 99456-W5 required a "MI" as an additional modifier for multiple impairment ratings.

   Per 28 Texas Administrative Code §134.204 states in part (j)(4))B)

   (4) The following applied for billing and reimbursement of an IR evaluation.

   (B) When multiple IRs are required as a component of a designated doctor examination under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier 'MI' shall be added to the MMI evaluation CPT code.

2. Review of the submitted documentation supports that the Division ordered the examination, yet any reimbursement methodology allowance per 28 Texas Administrative Code §134.204 for individual services was contingent upon the use of the modifiers explained in the entire rule. The medical bills submitted by the requestor for review does not reflect that the appropriate modifiers were applied according to the rule, therefore, reimbursement is disallowed.
3. The respondent has previously reimbursed the amount of $0.00 for the disputed CPT code 99456-W5. Therefore, the requestor is not entitled to reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 18, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.